Comprehensive Hospital Increase Reimbursement Program Stakeholder Feedback on Proposed Year 3 (State Fiscal Year 2024) Quality Measures and Reporting Requirements

As Required by

Texas Administrative Code

§353.1307

Texas Health and Human

Services Commission

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1. Overview

On January 4, 2023, HHSC released the draft quality measures and reporting requirements for Year 3 (State Fiscal Year 2024) of the Comprehensive Hospital Increase Reimbursement Program (CHIRP) for stakeholder feedback. The CHIRP Year 3 proposal documents included requirements (such as a program overview, measures, eligible CPT codes, and reporting requirements) and measure specifications (such as detailed information on measure specifications, attribution methodology, and payer type reporting stratification). On January 10, 2023, HHSC hosted a webinar to provide an overview of the CHIRP Year 3 proposed measures and requirements and answer stakeholder questions. Stakeholders submitted feedback through an online survey that closed on January 27, 2023.

This document summarizes the stakeholder feedback HHSC received through the 10 respondents to the survey, on behalf of nine organizations. HHSC reviewed and considered stakeholder comments and is not making any changes to the proposed measures in the Year 3 *CHIRP Measure Specifications* or *CHIRP Requirements*. However, updated file versions of the Year 3 *CHIRP Measure Specifications* and *CHIRP Requirements* have been published to the CHIRP Quality webpage. A new *CHIRP Measure Specifications FAQ* file for the proposed Year 3 measures has also been published to the CHIRP Quality webpage.

HHSC will include the quality measures and reporting requirements in the CHIRP state directed payment preprint submission to the Centers for Medicare & Medicaid Services (CMS) in March 2023. All CHIRP Year 3 requirements are subject to CMS approval. HHSC will post any changes required by CMS as described in 1 TAC §353.1307.

2. Stakeholder Comments

HHSC did not receive any feedback on Component 1 measure C1-105; Component 2 measures C2-104, C2-128, C2-129, C2-130, C2-132, C2-133, C2-141, C2-142, C2-158, C2-159, or C2-165; attribution methodology; or minimum volume requirements.

Based on stakeholder questions to clarify measure specifications for the proposed Year 3 measures, HHSC has published a new *CHIRP Measure Specifications FAQ* file for the proposed Year 3 measures to the CHIRP Quality webpage. HHSC will also continue to clarify any detailed measure specifications questions via email at DPPQuality@hhs.texas.gov.

Component 1

1. HHSC received requests to provide structure measure reporting questions earlier in the reporting process.

   HHSC Response: HHSC will try to give providers as much time as possible to review structure measure reporting questions.

2. Two respondents indicated general concerns that the existing C1-105: Health Information Exchange (HIE) Participation structure measure and the proposed new Non-medical Drivers of Health (NMDOH) Screening structure measure will require changes to electronic health records and workflow. They requested that if HHSC were to change these structure measures to process or outcome measures and/or make them pay for performance, that HHSC only do so carefully and with stakeholder input.

   HHSC Response: Structure measures are a type of measure (as opposed to "Process Measures" and "Clinical Outcome Measures") that help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. At this time, there are not any prescribed implementation or achievement requirements tied to a structure measure in any of the DPPs; the proposed structure measures require status reports only. As this proposal does not require implementation for payments, HHSC did not make any changes to these proposed measures.

C1-127: Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

3. HHSC received requests for additional resources for technical assistance in implementing C1-127: Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient.

HHSC Response: HHSC will continue to provide technical assistance to providers and look for additional guidance on reporting this measure.

C1-163: Non-Medical Drivers of Health (NMDOH) Screening and Follow-up Plan Best Practices

4. One respondent indicated they had no concerns with the NMDOH screening measure and proposed making the measure about the Accountable Health Communities Health-Related Social Needs Screening Tool specifically or as an alternative measure.

   HHSC Response: HHSC appreciates this feedback and will consider this when drafting specific reporting questions for this measure.

Component 2 - ACIA Rural Hospital Best Practices

C2-115: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

5. One respondent indicated that because they are in a rural area, they do not have many resources to offer their patients who screen positive for depression. They also indicated that providers in the emergency department (ED) may prioritize the primary reason for the ED visit and not complete the depression screening.

   Another respondent indicated that patients are screened for depression by their primary care provider (PCP), not at hospitals, and that patients may not want to follow up at the hospital. They suggested modifying the denominator to include only ED encounters. They also indicated they preferred the previous measure on influenza immunization.

   HHSC Response: HHSC did not make changes in response to these comments. HHSC has identified behavioral health as a priority area for additional quality improvement in Medicaid. Major depressive disorders and other/unspecified psychoses are among the top reasons for potentially preventable admissions and potentially preventable readmissions (PPRs), so screening and treatment are very important, and not all patients have an established relationship or timely access to a PCP. Untreated depression can not only cause health problems directly, but it may also indirectly worsen patient adherence to treatment for other conditions, such as hypertension and diabetes. During planning meetings for Year 3 changes, most stakeholders supported replacing the influenza immunization measure with this depression screening measure. For these reasons, HHSC has not made a change to the proposed measure.

Component 2 - ACIA Hospital Safety

C2-164: Postoperative Sepsis Rate

6. One respondent indicated they prefer measures that are universally applicable, and that they are concerned that smaller hospitals without surgical suites would be unable to report on this measure or participate in this module.

   HHSC response: Septicemia & Severe Infections are among the top reasons for potentially preventable complications in the STAR and STAR+PLUS programs and PPRs across Medicaid and CHIP. As the respondent acknowledged, this module is only designed for non-IMD state owned hospitals and urban hospitals. Any hospitals that do not perform surgery would accurately report that they have no elective surgical discharges, therefore they would report a denominator and numerator of 0, which would meet the conditions of participation.

Component 2 - ACIA Pediatric

7. One respondent provided general feedback about the proposed pediatric measure changes. They recommended further collaboration and discussion before making any of the proposed quality measures pay-for-performance and stated these measures are only appropriate for evaluation purposes. They expressed appreciation of HHSC's work to develop quality measures that are specific to children's hospitals, as care provided at children's hospitals is different from care provided in other settings.

   HHSC Response: HHSC appreciates the feedback. As the proposed measures do not include any pay-for-performance for Year 3, no changes were made.

C2-115: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

8. One respondent stated that some children's hospitals conduct this screening in an outpatient setting and not during inpatient care, so they were concerned this measure may not accurately capture work done in this area.

   HHSC Response: HHSC did not make any changes to the proposed measure because the denominator for this measure would already include both inpatient and outpatient encounters, except for lab- or imaging-only encounters.

General Comments

9. Two respondents from the same organization indicated stratifying by payer type is difficult and time consuming and requires manual chart audits.

HHSC Response: HHSC understands this requirement poses a challenge for some providers. However, as this is a CMS requirement, HHSC recommends providers make the process or system changes needed to stratify by payer type if they plan to continue participating in CHIRP. HHSC will try to facilitate the sharing of solutions among providers for this issue.

10. One respondent provided feedback that CMS approval and finalized measure specifications occurring late within the reporting period does not give them an opportunity to evaluate their processes and improve patient care before new metrics or metric modifications are required.

    HHSC Response: HHSC understands providers would like more notice and time for measure changes. CMS requires annual approval of these programs as they are currently structured. HHSC will continue to look for opportunities to involve stakeholders earlier in the process to gather feedback on proposed changes.

11. One respondent indicated that reporting twice per year increases provider burden and they would prefer to only report once per year.

    HHSC Response: HHSC did not make changes in response to this comment. Due to evaluation cycles, including preliminary evaluation data required by CMS, HHSC use two reporting periods in order to assess the preliminary six months of data for process and outcome measures. Additionally, having an initial reporting round for six months of data allows HHSC to provide feedback on any quality concerns that may affect the accuracy of the data reported.